NHS England

Never Events List 2015-16

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**02320**
Document Purpose	Consultations
Document Name	Draft revised Never Events Policy Framework for consultation
Author	NHS England/Patient Safety Domain
Publication Date	06 October 2014
Target Audience	CCG Clinical Leads, CCG Accountable Officers, Medical Directors, Directors of Nursing, NHS England Area Directors, GPs
Additional Circulation List	
Description	A core team of patient safety experts and health professionals have produced the initial draft of the revised framework, including professional organisations and NHS England staff in regional and area offices. Feedback received in consultation on the Standard Contract was also used to update sections of the policy. We are now seeking wider views and opinions on the proposed changes via the public consultation. The consultation closes on 31 October 2014. Responses will then be analysed and we will aim to publish the final revised Never Events Policy Framework by the end of the year, along with a summary of the consultation's findings.
Cross Reference	The never events policy framework
Superseded Docs (if applicable)	
Action Required	Review and feedback.
Timing / Deadlines (if applicable)	**By 31 October 2014**
Contact Details for further information	Joan Russell Head of Patient Safety Skipton House 80 London Road London SE1 6LH 07736 814478

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

The never events list

The following never events list is the list that all organisations providing NHS care should work from.

This is the revised list and definitions for use in the NHS from XXXX

SURGICAL
1. Wrong site surgery
A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, or wrong organ); the incident is detected at any time after the start of the procedure. • Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block, biopsy, radiological procedures, cardiology procedures, drain insertion and line insertion. • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes. • Excludes incidents where the wrong site surgery is due to incorrect laboratory reports or results **Setting:** All patients receiving NHS funded care. **Guidance:** - *Safer Practice Notice – Standardising Wristbands improves patient safety, 2007,* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824 - *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/ - *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901 - Safe Anaesthesia Liaison Group. Stop Before You Block. 2011. http://www.rcoa.ac.uk/index.asp?PageID=1763
2. Wrong implant/prosthesis
Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in

the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

- Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure
- Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

Setting: All patients receiving NHS funded care.

Guidance:
- *Safer Practice Notice – Standardising Wristbands improves patient safety, 2007,* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824
- *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/
- *Safer Surgery Checklist for Cataract Surgery,* 2010, available at http://www.rcophth.ac.uk/page.asp?section=365&sectionTitle=Information+
- *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901

3. Retained foreign object post-procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas

'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guidewires) **except where:**

- Items are inserted during the procedure but are intentionally retained after completion of the procedure, with removal planned for a later time or date
- Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention

- Items were inserted at an earlier date or time and not removed as planned during a later surgical/invasive procedure

See the **Appendix X on page X** for examples of correct application of this never event definition.

Settings: All patients receiving NHS funded care.

Guidance:
- *Standards and recommendations for safe perioperative practice*, 2007, available at http://www.afpp.org.uk/news/safe-practice-highlighted-in-new-afpp-publication
- *Swab, instrument and needle counts: Managing the risk*, 2005, available at http://learning.afpp.org.uk/documents/SwabA2Poster2007.pdf
- *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/
- *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901
- *Reducing the risk of retained throat packs after surgery*, 2009, available at -http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853
-*Reducing the risk of retained swabs after vaginal birth and perineal suturing,* 2010, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113
- *Risk of harm from retained guidewires following central venous access*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829
- *Tracking subsequent removal of intentionally retained swabs*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132834&p=2

Consultation point: The proposed never event includes retained vaginal swabs following home delivery when only one midwife is present. Do you consider the established guidance provides a very strong barrier to a lone practitioner inadvertently leaving a swab *in situ*?

MEDICATION

4. Wrongly manufactured high-risk injectable medication

A high-risk injectable medication is wrongly manufactured in a hospital pharmaceutical department with the intention of it being administered to a patient. This includes products manufactured aseptically on the ward in aseptic cabinets but does not include simple dilution in

a ward situation.

- High-risk injectable medicines are defined as those listed by the NHS Aseptic Pharmacy Services Group[1].
- High risk injectable medication is considered wrongly manufactured if manufacture was not compliant with the manufacturer's Specification of Product Characteristics;

Setting: All patients receiving NHS funded care.

Guidance:
- Medicines and Healthcare Products Regulatory Agency
http://www.mhra.gov.uk/Safetyinformation/Medicinesinformation/SPCandPILs/
- Patient Safety Alert - Promoting safer use of injectable medicines, 2007, available at http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59812&p=4
- Multiple use of single use injectable medicines, 2011, available at http://www.nrls.npsa.nhs.uk/resources/type/signals/?entryid45=130185

5. Maladministration of a potassium-containing solution

Maladministration of a potassium-containing solution. Maladministration refers to;

- selection of strong[2] potassium solution instead of intended other medication,

Setting: All patients receiving NHS funded care.

Guidance:
- Patient safety alert – Potassium chloride concentrate solutions, 2002 (updated 2003), available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59882
- Standard Operating Protocol fact sheet; Managing Concentrated Injectable Medicines, part of the WHO High 5's project, available at https://www.high5s.org/bin/view/Main/WebHome

Consultation point: Earlier definitions of this Never Event also included 'infusion at a greater rate than intended'. Do you consider any established guidance provides a very strong barrier to delivering an infusion at the wrong rate, and therefore justifies including this in the Never Event definition? If such guidance exists, is it feasible to have an unambiguous definition of what constitutes infusion at a rate greater than intended, given delivery at rates only slightly higher than intended are unlikely to present a significant risk to patients?

[1] Pharmaceutical Aseptic Services Group. Example risk assessment of injectable medicines. 2007. Available at http://www.civas.co.uk/NPSA/Approved-NPSA-injectables-list-Oct-2012.pdf

[2] ≥10% potassium w/v (e.g. ≥ 0.1g/ml potassium chloride, 1.3mmol/ml potassium chloride)

6. Wrong route medication

Wrong route administration of liquid medication or enteral feed

The patient receives one of the following:

- Intravenous chemotherapy that is correctly prescribed but administered via the intrathecal route
- Oral/enteral medication feed or flush administered by any parenteral route
- Intravenous administration of a medicine intended to be administered via the epidural route

Setting: All patients receiving NHS funded care.

Guidance:
- HSC2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy, 2008, available at http://www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/healthservicecirculars/dh_086870
- Rapid Response Report NPSA/2008/RRR004 using vinca alkaloid minibags (adult/adolescent units), 2008, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59890
- Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132897
- Safer spinal (intrathecal), epidural and regional devices, 2011, available at http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=94529
- Patient safety alert on non-Luer spinal (intrathecal) devices for chemotherapy 2014. available at http://www.england.nhs.uk/2014/02/20/psa-spinal-chemo/
- Patient Safety Alert NPSA/2007/19 - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59808
- Patient Safety Alert NPSA/2007/21, Safer practice with epidural injections and infusions, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59807

7. Maladministration of Insulin

Maladministration of insulin by a health professional.

Maladministration in this instance refers to a tenfold or greater overdose of insulin administered to the patient:

- when a health professional(s) abbreviates the words ‘unit’ or ‘units’ when prescribing insulin in writing
- when a health care professional fails to use a specific insulin administration device e.g. an insulin syringe or insulin pen to draw up or administer insulin

Setting: All patients receiving NHS funded care.

Guidance:
- *Rapid response report – Safer administration of insulin*, 2010, available at http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287
- *NHS Diabetes – Safe use of insulin, 2010,* available at http://www.diabetes.nhs.uk/safe_use_of_insulin/
- *NHSIII Toolkit – Think Glucose, 2008,* available at www.institute.nhs.uk/thinkglucose
- *NHS Diabetes guidance - The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus,* 2010, available at *http://www.diabetes.org.uk/About_us/Our_Views/Care_recommendations/The-hospital-management-of-Hypoglycaemia-in-adults-with-Diabetes-Mellitus/*

8. Wrong frequency administration of methotrexate for non-cancer treatment

Supply or administration of methotrexate by any route to a patient for non-cancer treatment more frequently than the required once weekly treatment.

- Excludes cancer treatment with daily oral methotrexate
- Excludes where the error is intercepted before the patient is supplied with the medication.

Setting: All patients receiving NHS funded care.

Guidance:
- *Patient safety alert - Improving compliance with oral methotrexate guidelines*, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59800

Consultation point: Earlier definitions of this Never Event also included 'prescription'. Do you consider any established system or guidance is available that provides a very strong barrier to wrong prescribing in all sectors?

MENTAL HEALTH

9. Failure to install functional collapsible shower or curtain rails

Involves either;

- failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted.
- failure to install collapsible rails and an inpatient suicide is attempted using these non-collapsible rails

Setting: All mental health inpatient premises.

Guidance:

- *NHSE SN (2002) 01: Cubicle rail suspension system with load release support systems,* 2002, available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_4122863?PageOperation=email
- *NHSE (2004) 10: Bed cubicle rails, shower curtain rails and curtain rails in psychiatric in-patients settings,* 2004, available at www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/estatesalerts/dh_4119476
- *Clinical guideline 16 – self-harm: the short term physical and psychological management and prevention of self-harm in primary and secondary care,* 2004, available at www.nice.org.uk/guidance/CG16
- *DH (2007)08: Cubicle curtain track rails (anti-ligature),* 2007, available at http://www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/estatesalerts/dh_076400

GENERAL

10. Falls from unrestricted windows

A patient falling from an unrestricted window.

- Applies to windows "within reach" of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.
- Includes windows located in facilities/areas where healthcare is provided and where patients can and do access.
- Includes where patients deliberately or accidentally fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall.

Setting: All patients receiving NHS funded care

Guidance:
- *Health Technical Memorandum (HTM) 55: Windows*, available via http://www.spaceforhealth.nhs.uk/England/space-health (login required)
- *DH(2007)09 – Window restrictors,* 2007, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080164.pdf
- *Risk of falling from windows*, available at http://www.hse.gov.uk/healthservices/falls-windows.htm

11. Chest or neck entrapment in bedrails

Entrapment of a patient's chest or neck within bedrails, or between bedrails, bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance

Setting: All settings providing NHS funded healthcare, including NHS funded patients in care home settings, and equipment provided by the NHS for use in patients' own homes.

Guidance:
- *Safer practice notice – Using bedrails safely and effectively,* 2007, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59815
- *DB 2006(06) v 2.1 Safe use of bed rails,* Dec 2013, available at

http://www.mhra.gov.uk/home/groups/dts-bs/documents/publication/con2025397.pdf
- *Local Authority Circular - Bed Rail Risk Management,* 2003, available at http://www.hse.gov.uk/lau/lacs/79-8.htm
- *Safe use of bedrails*, available at http://www.hse.gov.uk/healthservices/bed-rails.htm

12. Transfusion or transplantation of ABO-incompatible blood components or organs

Inadvertent transfusion of ABO-incompatible blood components.

- Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management.

Inadvertent ABO mismatched solid organ transplantation.

- Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately
- In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management.

Setting: All patients receiving NHS funded care.

Guidance:
- *Safer Practice Notice – Right Patient, Right Blood*, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59805
- *SHOT Lessons for clinical staff,* 2007, available at http://www.shotuk.org/wp-content/uploads/2010/03/SHOT-lessons-for-clinical-staff-website.pdf
- *SHOT Lessons for Clinical Staff* 2009, available at http://www.shotuk.org/wp-content/uploads/2010/12/Lessons-for-Clinical-Staff-Dec-2010.pdf
- *BSHI and BTS Guidelines for the Detection and Characterisation of Clinically Relevant Antibodies in Allotransplantation,* 2010, available at http://www.bshi.org.uk/pdf/BSHI_BTS_guidelines_2010.pdf
- *Antibody incompatible transplant guidelines*, 2011, available at http://www.bts.org.uk/transplantation/standards-and-guidelines/
- *Patient Safety Alert – WHO Surgical Safety Checklist,* 2009, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59860

13. Misplaced naso- or oro-gastric tubes

Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration.

Setting: All patients receiving NHS funded care.

Guidance:
- *Patient safety alert – Reducing harm caused by misplaced nasogastric feeding tubes,* 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59794
- *Patient safety alert – Reducing harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units*, 2005, available at

http://www.nrls.npsa.nhs.uk/resources/?entryid45=59798&q=0%c2%acnasogastric%c2%ac
- *Reducing the harm caused by misplaced naso-gastric feeding tubes in adults, children and infants*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=129640&p=2
- *Harm from flushing of naso-gastric tubes before confirmation of placement*, 2012. available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=133441
Patient safety alert on placement devices for nasogastric tube insertion - http://www.england.nhs.uk/2013/12/05/psa-ng-tube/

14. Scalding of patients

Patient being scalded by water used for washing/bathing

- Excludes scalds from water being used for purposes other than washing/bathing (e.g. from kettles)

Settings: All patients receiving NHS funded care.

Guidance:
- *Health Technical Memorandum 04-01 - The control of* Legionella*, hygiene, "safe" hot water, cold water and drinking water systems*, 2006, available via https://publications.spaceforhealth.nhs.uk/index.php?option=com_documents&task=list_search&Itemid=1 (login required)
- *Hospital Technical Memorandum HTM64 (Sanitary assemblies)*, 2006, available from *http://www.spaceforhealth.nhs.uk/* (login required)
- *NHS Model Engineering Specification D08 (Thermostatic Mixing Valves – healthcare premises)*, 1999, available from *http://www.spaceforhealth.nhs.uk/* (login required)
- *Scalding risks from hot water in health and social care LAC: 79/5,* 2007, available at http://www.hse.gov.uk/lau/lacs/79-5.htm
- *Scalding and burning*, available at http://www.hse.gov.uk/healthservices/scalding-burning.htm